

# Ryan White Enrollment Application - Secondary Dental Services

Secondary Dental serves individuals with medical insurance but no dental insurance.  
**Individuals with no medical insurance should be enrolled in Ryan White Primary Care using form RW-1.**  
Clients will be registered only with the submission of this fully completed form and required supporting documentation.

**PRINT**

Last Name		First Name		MI	Social Security #	Mother's Maiden Name
Date of Birth	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MTF <input type="checkbox"/> FTM		Housing Status <input type="checkbox"/> Rent; <input type="checkbox"/> Own; <input type="checkbox"/> Rent room; <input type="checkbox"/> Live with family/ friends; <input type="checkbox"/> Substance Abuse Treatment Facility; <input type="checkbox"/> Assisted Living Facility; <input type="checkbox"/> Homeless			
Hispanic? <input type="checkbox"/> Yes; <input type="checkbox"/> No		Race: <input type="checkbox"/> White; <input type="checkbox"/> Black; <input type="checkbox"/> Asian; <input type="checkbox"/> American Indian/Native Alaskan; <input type="checkbox"/> Pacific Islander; Other: _____				
Home Address					City	
ZIP	County	Phone # Include Area Code		Gross monthly income \$	Household Size	
HIV/AIDS Status: <input type="checkbox"/> HIV positive, disease stage unknown; <input type="checkbox"/> HIV positive, asymptomatic; <input type="checkbox"/> HIV positive symptomatic, not AIDS; <input type="checkbox"/> HIV positive, disabling; <input type="checkbox"/> CDC-Defined AIDS; <input type="checkbox"/> Disabling AIDS					Year Status Effective	
HIV/AIDS status documentation: <input type="checkbox"/> Letter of Diagnosis; <input type="checkbox"/> Medical Record; <input type="checkbox"/> Lab Results						

**1. Other Coverage/Insurance**

- a. Does client currently have Medi-Cal (Denti-Cal) coverage or dental insurance? ☐ Yes ☐ No (If "No" go to 1d)
- b. If 1a is "Yes", Name of insurer: \_\_\_\_\_ Exp: \_\_\_\_\_  
Member # \_\_\_\_\_  
**Copy both sides of the insurance card and retain with this application.**
- c. If 1a is "Yes" is this procedure covered by Denti-Cal or insurance? ☐ Yes ☐ No  
If 1c is "Yes" STOP; the individual is not eligible for Secondary Dental for this procedure.  
If 1c is "No", **attach the denial notice from the insurance carrier** (not needed for Denti-Cal).
- d. Medical insurer/coverage \_\_\_\_\_  
Member # \_\_\_\_\_ End Date \_\_\_\_\_  
**Copy both sides of the insurance card and retain with this application.**

**2. Eligibility (The following are program requirements; indicate completion by checkmark prior to faxing this form to UnitedHealthcare.)**

- ☐ Response to 1a is "No" and 1d is completed or 1a is "Yes" and 1c is "No".
- ☐ HIV/AIDS status documentation has been provided and a copy is retained with this application.
- ☐ Applicant has signed the ARIES Client Consent Form and a copy is retained with this application.
- ☐ Applicant has provided his/her insurance card and a copy is retained with this application.
- ☐ Applicant has provided a denial letter and a copy is retained with this application.

All information on this form is accurate to the best of my knowledge

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff completing this form: \_\_\_\_\_  
Name/Title ( )  
Agency/Clinic Phone Number

**Submit this completed application and denial notice (if applicable) to UnitedHealthcare via fax number (858) 495-1329**